CHAPTER IV

COVERED SERVICES AND LIMITATIONS

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DEFINITION OF CASE MANAGEMENT SERVICES

Case management services are an integral component of the overall service delivery system for dependent elderly individuals. Virginia offers case management services to enable the assessment, coordination, and monitoring of the needs of qualified elderly persons. Case management services are viewed as an indirect service necessary to the successful avoidance of institutional care. Case management enables the efficient and effective delivery of the other direct services which are viewed as the services responsible for the delay or avoidance of institutionalization (for example, personal care, chore, companion, home-delivered meals, adult day health care, and respite care).

Every Medicaid eligible individual authorized for case management services must be 60 years of age or older, live within the approved geographic area described in Chapter II, and be dependent in at least two or more of the following activities of daily living: bathing, dressing, toileting, continence, or eating. In addition, each individual must have a demonstrated unmet need that requires case management intervention or coordination of services in order for that individual to continue to reside safely in the community. This unmet need must be clearly documented. An identified need for case management services is defined as:

- The individual requires coordination of multiple services but does not currently have support available to assist with identifying, accessing and coordinating of these services, and a referral to a formal or informal support system will not meet the individual's needs; or

- An identified problem exists in one of the following areas: physical environment, support system, financial support, emotional health or physical health. These problems must be addressed to ensure the individual’s health and welfare. Other formal or informal supports have either been unsuccessful in their efforts or are unavailable to assist the individual.

CASE MANAGEMENT PROVIDER RESPONSIBILITY

Each individual referred for case management services must be assessed by an agency participating in the Elderly Case Management Program, which is responsible for authorizing Elderly Case Management Services. Each case management agency must have a current DMAS contract. The agency must also:

- Employ case managers who meet the qualifications set forth by DMAS;

- Serve individuals who are Medicaid eligible;

- Be located in one of the geographic localities where elderly case management services are available; and

- Authorize case management services and refer those individuals to appropriate case management provider agencies.

CASE MANAGER RESPONSIBILITIES AND AUTHORIZATION PROCESS

Once an assessment is completed and authorization for case management services is given, the four-page Uniform Assessment Instrument (UAI) is forwarded to the Case Management provider chosen by the recipient. If more than one provider is available in the locality where the recipient resides, he or she must be given freedom of choice of participating providers. A case manager must be assigned to:

- Develop a plan of care that specifies the resources, referrals, and activities the case manager will use or perform to meet the identified needs documented on the uniform assessment instrument. Specify the time frame for each activity and the expected length of stay in case management services;

- Verify the individual's status as a Medicaid eligible recipient by viewing a recipient identification card with a valid effective date or by contacting the local Department of Social Services (DSS) to verify Medicaid eligibility. Every Medicaid eligible individual is assigned a 12-digit Medicaid identification number and is issued a Medicaid identification card each month that the individual is eligible. Providers may also contact the Audio Response System at the toll free number 1-800-884-9730;

  Providers access the Audio Response System using their Virginia Medicaid provider numbers as identification. Specific instructions on the use of the system are included in "Exhibits" at the end of Chapter I;

- Send a copy of the plan of care and the first four pages of the UAI to DMAS for enrollment in the DMAS system, so that the provider can bill for services rendered. Initial Medicaid-funded Elderly Case Management service authorizations may be enrolled for a maximum of six (6) months;

- Maintain a recipient record including the assessment instrument, plan of care, daily log, and progress report; and

- Terminate services upon completion of the activities on the plan of care, or request an extension if there is an identified need for additional case management services beyond the authorization period.

The Case Management provider must render reliable, continuous services. Any time the provider is not able to render care to a recipient, the case manager must transfer services to another provider if one is available within the specified geographical area.

A Medicaid eligible individual residing in a nursing home within the approved geographic area may be authorized to receive case management services for a maximum period of 30 days prior to discharge in order to coordinate home- and community-based services to enable the individual's discharge to the community. Upon discharge, the individual must reside within the approved geographic area to continue to received case management. Services rendered more than 30 days prior to discharge will not be reimbursed by DMAS should the individual continue to reside in the nursing home. The activities of the case manager may not duplicate those which are the responsibility of the nursing home's discharge planner.

The case manager is the individual designated by the case management provider as responsible for developing the initial plan of care, conducting the re-evaluation, and reviewing the individual's plan of care.

COVERED SERVICES

Case management services will be reimbursed only for those contacts made directly by the case manager, not by any individuals supervised by the case manager having interaction with the elderly case management recipient.

The case manager may provide any assessment, coordination, monitoring, or referral services necessary as a part of managing the recipient's care in the community. This activity must be documented in the monthly log maintained by the agency and must, upon review by DMAS staff, be deemed necessary and consistent with high-quality care assurance.

Typical case management activities which are reimbursable by DMAS include, but are not limited to:

- An initial assessment visit with the recipient in the recipient's residence during which the plan of care is developed;
- Contacts with the direct service providers for the purposes of referral for service, monitoring of current service delivery, problem solving and technical assistance, changes to the case management plan of care, etc.;
- Contacts with the recipient, friends, family, physician, and other professionals involved in the recipient's care for the purposes of assessment, coordination, and monitoring;
- Occasional revisions to the case management plan of care; and
- Subsequent re-evaluations conducted with the recipient and case management team during which the UAI, and case management plan of care if necessary, are updated.

Some examples of when case management services would not be appropriate are if the only service needed is to manage routine medical appointments or to wait for nursing facility placement after preadmission screening and other arrangements have been made.

FORMS REQUIRED FOR ENROLLMENT IN THE ELDERLY CASE MANAGEMENT PROGRAM

The case management agency which is initiating a referral will send the case management provider a copy of the UAI and a letter of referral indicating that the individual is eligible for the case management program for the elderly and is Medicaid eligible, giving the Medicaid identification number. The case management provider will complete a Plan of Care. The provider will submit a copy of the Plan of Care and the first four pages of the UAI to:

WVMI
Bank of America Building, Suite 402
Attn: CBC Review
111 East Main Street
Richmond, VA 23219

Incomplete enrollment packets will be returned to the provider, with a request that a complete packet be resubmitted.

The plan of care is returned to the provider agency as its permission to bill after the recipient has been enrolled in services. If the recipient is not enrolled, the plan of care will be returned to the provider agency with an explanation noted by the enrollment analyst.

CASE RECORD DOCUMENTATION REQUIREMENTS

Upon the receipt of a referral and the four-page UAI, the case management provider will contact the recipient and initiate the Plan of Care. The case manager will create a recipient file and begin documentation on a monthly log by recording the first contacts with the recipient, to develop the Plan of Care, and with direct service providers, to refer the recipient for needed services and to monitor service implementation (see Chapter VI for the contents of the recipient file and the data required for inclusion in the monthly log). The case manager must record a summary of the first 30 days of service delivery to the recipient on a recipient progress report. Every 30 days thereafter, the case manager must record a summary of the recipient's status and the status of his or her service delivery system in the recipient progress report (see Chapter VI, for the contents of the recipient progress report). The use of the Elderly Case Management monthly log and recipient progress report are not mandatory. However, the case management provider must record in a format which allows review by state and federal review staff and which includes all of the required information (as stated in Chapter VI) if the DMAS form is not used.

CASE MANAGEMENT PLAN OF CARE

The case manager is responsible for developing the Case Management Plan of Care prior to initiation of any services. The following information should be documented:

- Problems identified on the UAI and the services to be implemented. Describe in detail the specific activities, resources, and referrals that will be accessed and used to meet the needs of the recipient;

- The expected time frame needed for completion of each activity and the expected length of stay in case management services not to exceed 6-months;

- The start of care date, the recipient's name, Medicaid number, the recipient's signature, and the date must be on the form; and

- The case management provider's name and provider number, the signature of the case manager, and the date.

The Case Management Plan of Care and the four-page UAI must be completed and submitted to WVMI for enrollment in order for the Case Management provider to bill for case management services. Any bill submitted for reimbursement prior to the receipt of these documents and the enrollment of the recipient will not be paid.

CASE MANAGEMENT AGENCY MONITORING OF RECIPIENT SERVICES

The case management agency is responsible for monitoring the ongoing provision of services to each Medicaid elderly case management recipient. This monitoring includes:

- The adequacy of the service to meet the recipient's needs;

- The functional and medical needs of the individual and any modification necessary to the Plan of Care due to a change in these needs; and

- The individual's need for additional services that are not available in the community, which includes an overall assessment of the individual's safety and welfare in the home.

The case management provider agency is responsible for taking the appropriate action to assure appropriate, adequate, and timely service to elderly case management recipients. Appropriate actions may include: discussions with direct service providers regarding the services to be provided to the recipient and discussions with the recipient and his or her family about the need for additional services, if necessary.

REAUTHORIZATION

Case management services may not continue for more than the authorized time frame without approval from WVMI. The case manager may request reauthorization of case management services. The request for a reauthorization for additional services must be submitted to WVMI in writing prior to the end of the current authorization period. There will be no retroactive approvals of services before the review of the mailed-in request. Requests that are mailed in should be addressed to:

WVMI
Bank of America Building, Suite 402
Attn: CBC Review
111 East Main Street
Richmond, VA 23219

The request must include:

- A summary of the case management services to-date and the reason that case management services continue to be required to safely maintain the individual in the community;
- A copy of the most recent Plan of Care; and
- An estimate of the additional length of time that case management services will be needed. WVMI may deny the request or approve a shorter time frame if the reason for the reauthorization is not clear or appears unwarranted.

TERMINATION

Once a recipient is determined to no longer require Elderly Case Management services, the case manager is expected to terminate services. The case manager must complete a Case Management Outcome Report, submit a copy to WVMI, and send the recipient a letter that notifies him or her of the reason for termination and includes a statement of the right to appeal.

RIGHT TO APPEAL – PROVIDER TERMINATION

Any time a case manager decides to terminate services, the individual must be notified by letter that services will be terminated and must be given the right to appeal. The following statement must be included in every recipient letter of termination of service:

> You may appeal this decision by sending a written request to the, Appeals Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219. The request must be postmarked within thirty (30) days of the date of this letter. If you file an appeal before the effective date of this action, services may be continued. However, if it is determined at the hearing that the sole reason for the appeal is disagreement with state regulations, Medicaid coverage may be discontinued at the hearing. If the hearing officer determines the action taken by the Case Manager was correct; you may be required to reimburse DMAS for the expenditures made on your behalf during the appeals process.

When the request for an appeal is received, a letter is sent to the recipient and a copy to DMAS validating the appeal and scheduling a hearing.

If the recipient files an appeal before the effective date of the action, the hearing officer notifies the recipient in writing that his or her services can continue unchanged during the

appeal and that the recipient should contact the Appeals Division if he or she does not wish services to continue. The Appeals Division sends a copy of this letter to the provider and the WVMI to inform all parties of the continuation of services. If the reassessment does not indicate a change that would invalidate the initial decision, the case manager should document this in the appeal summary. If the summary has already been submitted, the case manager should send a letter to the recipient which details the outcome of this re-assessment and states that the initial decision continues to be valid. A copy of this letter should be sent to the appeals hearing officer. When the case manager receives notice that an appeal has been validated, there will be 10 days to prepare and submit an appeals summary. The case manager must send a copy of the appeals summary package (the appeals summary and all attachments) to all parties who have been notified of the hearing, including an attorney or other legal representative.

The appeal summary must be written with the assumption that the individuals who will read it have no knowledge of the individual's circumstances or of the policies. It should summarize the individual's status at the time the action was taken, what action was taken, and the reason for the action.

A hearing will be held at the site scheduled by the hearing officer. During the hearing, the hearing officer will ask the case manager to summarize the case manager's actions. The case manager should give a brief summary of the action taken and the reasons for the action. During this summary, the case manager can introduce any information omitted from the appeal summary. The hearing officer will then ask the recipient to respond, giving the reasons he or she thinks the action should be reversed. It is the case manager's role during the hearing to take notes, clarify points of discussion, and ask questions to ensure the WVMI's actions are clearly understood.

Following the appeal hearing, the hearing officer will make the final determination to sustain or overturn the action taken by the case manager. The case manager will be informed of the hearing officer's decision. In cases where the case manager's decision has been sustained and the recipient has continued to receive services, the Appeals Division should notify the recipient if the recipient is responsible to pay for these continued services.

RIGHT TO APPEAL – DMAS TERMINATION OR REDUCTION OF SERVICES

Any individual wishing to appeal should notify the Appeals Division, Department of Medical Assistance Services, in writing, of his or her desire to appeal within thirty days (30) of receipt of the DMAS decision letter. Appeal requests should be sent to the Appeals Division, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219. If an appeal is filed before the effective date of this action, services may continue during the appeal process. However, if this decision is upheld by the Hearing Officer, the recipient may be required to reimburse the Medical Assistance Program for the cost of services provided after the date of WVMI termination.

When a request for an appeal is received, the Appeals Division will send a letter to the recipient and a copy to DMAS validating the appeal and scheduling a hearing. The Appeals Unit will be responsible for determining the relevant parties to be involved in the hearing process.

If the recipient files an appeal before the effective date of the action, the hearing officer notifies the recipient in writing that services can continue unchanged during the appeal and that the recipient should contact the Appeals Division if he or she does not wish services to continue. A copy of this letter is sent by the Appeals Division to the provider and the WVMI Review Analyst assigned to the case to inform all parties of the continuation of services.

The hearing officer will send the decision and all the exhibits to the appellant. This is the agency's final administrative action. If the appellant disagrees with the hearing officer's decision, he or she may request a review of the decision by his or her local circuit court. Information concerning the circuit court review will be included with the hearing officer's decision.